MEDICATION PERMISSION

Physician's Order for Administration of Oral or Topical Medication by Child Care Providers

Child's Name: _____

Address: _____

_____ Phone: _____

I have prescribed the following medication for the above child and request that dosage below be administered by child care personnel during care hours.

Medication: _____

Prescribed for what reason: _____

Prescribed dosage: _____

Medication to start: _____ To end: _____

Remarks (reactions, etc.):

_____ _____

(Printed name of physician) (Signature) (Date)

Work address: _____

_____ Phone: _____

PARENTAL RELEASE FOR ADMINISTRATION OF MEDICATION

I give my permission for the above medication to be given to my child as prescribed by the above physician.

I release the above child care providers of any and all liability in the administering of the above medication.

Date: _____ _____

(Parent/Legal guardian signature)

Reset